BEFORE THE APPEALS BOARD
FOR THE
KANSAS DIVISION OF WORKERS COMPENSATION

JOSEPH L. SUTTON	)	
Claimant	)	
VS.	)	
	)	
JOHN DEERE LANDSCAPING	)	
Respondent	)	Docket No. 1,007,316
AND	)	
	)	
AMERICAN HOME ASSURANCE COMPANY	)	
C/O AIG	)	
Insurance Carrier	)	

ORDER

Claimant requested review of the June 17, 2004 Award entered by Administrative Law Judge (ALJ) John D. Clark. The Appeals Board (Board) heard oral argument on November 16, 2004.

APPEARANCES

Stephen J. Jones of Wichita, Kansas, appeared for claimant. Bradley J. LaForge of Wichita, Kansas, appeared for respondent and its insurance carrier.

RECORD AND STIPULATIONS

The Board considered the record and adopts the stipulations as listed in the Award.

ISSUES

In his June 17, 2004 Award the ALJ adopted the opinion of the independent medical examiner, Philip R. Mills, M.D., and granted claimant compensation based upon a one percent permanent partial impairment to his right arm.

Claimant argues that the ALJ should have granted a whole body impairment and a work disability based on the opinions of Drs. Lucas, Melhorn and Murati, who allegedly

opined claimant suffered from reflex sympathetic dystrophy (RSD). Instead, the ALJ relied on the opinion of Dr. Mills, who saw claimant only one time.

Respondent contends the ALJ's finding of one (1) percent scheduled injury to the right arm should be affirmed but raises additional issues. Respondent alleges an overpayment of temporary total disability compensation (TTD). Respondent also requests a disallowance of/or credit for portions of the medical expenses including a finding that all medical care which has not been presented for consideration is unauthorized and not owing at this time. Respondent also argues that claimant's right to future medical should be terminated.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Claimant started working for respondent in the spring of 2002.[1] Claimant was hired to drive a truck and make deliveries around the state of Kansas. This sometimes entailed heavy labor.

Part of claimant's job duties included pre-trip inspections of the truck, including getting out and physically touching components around the truck, checking under the hood to inspect the belts, crawling underneath the truck, checking brake lights and making sure the tires were at the right pressure. Before delivering materials claimant also had to check his air tanks, ensure the load was secure, check the weight and map out which direction he was going to take.

On June 10, 2002,[2] claimant was delivering landscape materials and trees from Wichita to one of respondent's regular customers in Hutchinson, Kansas. It was his usual routine to make deliveries to Hutchinson three (3) times a week. This time claimant was sent to deliver trees to Mennonite Manor and to meet the maintenance man on the property in order to turn over the landscaping materials he had in his truck. Upon arriving at the site claimant discovered the trees were too large for the equipment. After all the other materials were unloaded claimant testified he jumped off the bed of the truck because his side rail was on the ground. He grabbed the side rail and handed it up to one of the care home's maintenance men. While placing the side rail back into the truck, the side rail dropped on claimant's right hand. Claimant testified he felt immediate pain in the rotator cuff area. The truck is approximately chest high. Claimant testified he believed the

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[1] Sutton Depo. at 37.

[2] At page 3 of the regular hearing transcript counsel for claimant stated that the accident date was May 10, 2002, and claimant likewise testified to the May 10 accident date at pages 7 and 8. But in the claimant's submission brief to the ALJ, under "Stipulations" the accident date is given as June 10, 2002. However, respondent's submission brief refers to May 10, 2002 as the alleged date of accident. The ALJ's Award found the date of accident to be June 10, 2002. Date of accident was not raised as an issue to the Board therefore, the Board will use June 10, 2002, as the date of accident.

side rail panels weigh "at least 40 to 50 pounds."[3] At the preliminary hearing on December 17, 2002, claimant described his symptoms as feeling "like a chip on my ring finger on my right hand at the first bend, my first knuckle, the first bend on my first knuckle. It was sort of awkward, it was on like the side of my finger, wasn't on the top of the bottom. It was almost like it caught it."[4]

Claimant made two more stops on his route before going back to Wichita. When claimant reported the accident to respondent, claimant testified he was told by respondent to pick an emergency room and to seek medical attention there if the pain continued. Although claimant went to work the day after the work-related accident, he did not perform his normal duties. Instead, he simply drove a truck with no loading or unloading involved.

As claimant could no longer drive because shifting gears was difficult respondent hired a Spanish speaking driver that claimant rode along with to make deliveries. Claimant testified that he rode with him twice helping load and unload the truck. Apparently there was a language barrier between the new driver, who only spoke Spanish and very little English, and the claimant, who did not speak Spanish. Claimant testified this arrangement did not work out as some of the clients did not speak Spanish and also because he had to step in and out of the truck.[5] Claimant testified that respondent wanted him to ride along and train the new driver but claimant stated he did not think that would work because he could not communicate with the new driver due to the language barrier, nor could some customers. Also,"[i]t wasn't in my job description."[6] After notifying respondent that this was not going to work out claimant testified he worked around respondent's premises sweeping floors and waiting on customers.[7]

After receiving permission from respondent, claimant first sought medical attention on June 11, 2002, at the West Wichita Minor Emergency Office and was seen by Joe D. Davison, M.D. Dr. Davison reviewed x-rays and diagnosed claimant with a distal tuft fracture or a contusion of the fourth distal finger on the right hand.[8] Treatment included medications, ice, keeping the finger elevated and wearing a splint. Dr. Davison also restricted claimant from the use of the finger by wearing the splint. Initially, Dr. Davison did not impose restrictions but instead allowed claimant's employer to set restrictions based

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[3] Sutton Depo. at 59

[4] P.H. Trans. at 12 (Dec. 17, 2002).

[5] *Id.* at 33.

[6] R.H. Trans. at 14 (Feb. 4, 2004).

[7] Sutton Depo. at 88.

[8] Davison Depo. at Ex. 2.

on what they deemed was appropriate. However, after claimant called Dr. Davison's office the following day he then placed restrictions on claimant of no use of the right hand and faxed those to respondent.

Claimant called Dr. Davison's office on June 12, 2002, complaining that he was not going to be able to work. Claimant stated since the last visit his hand was markedly swollen and black and blue. Dr. Davison believed claimant to be fabricating a story to continue to stay on a work sabbatical. Dr. Davison originally stated that claimant can go to work without the use of the right hand with a recheck after an appropriate period of time, but that he was not going to keep him completely off work. Dr. Davison did not feel comfortable giving him complete restrictions based upon his findings and reiterated that his restrictions of using the one hand still stood, but that he must go to work. Dr. Davison did state that if the swelling had gotten worse, claimant has the opportunity to return to the office for re-evaluation.[9]

On or about June 16, 2002,[10] respondent offered claimant an accommodated position to ride with the new driver to Colby, Kansas. But claimant was on medications and did not feel it was safe to drive. Claimant also said he had trouble driving, loading and unloading with one hand. Respondent contends claimant was not expected to drive, load or unload, he was only to ride along and train the new worker. Eventually, claimant was terminated due to excessive absences. Respondent made repeated attempts to accommodate claimant's injury and restrictions, but for one reason or another, none of the jobs were satisfactory to claimant. The Board finds claimant failed to make a good faith effort to perform the accommodated jobs with respondent. As work was available that claimant was physically capable of performing, temporary total disability compensation is denied.

Claimant saw Dr. Davison for a followup visit on June 19, 2002. Dr. Davison's records reflect claimant did not have any obvious signs of fracture and that the distal finger looked good. There was no discoloration and the color was good. There were no nail blanching defects or other abnormalities. According to his records claimant's range of motion was slightly decreased but the note reflected it was hard to tell if it was real or voluntary. Dr. Davison's assessment was distal finger phalanx tip fracture and he continued claimant on restrictions. Dr. Davison said that he would consult with occupational therapy. Dr. Davison's chart notes reflect that claimant was scheduled for occupational therapy for one week on June 21, 2002 at St. Joseph's Via Christi Rehabilitation, and then for occupational therapy for three (3) weeks beginning June 26, 2002.

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[9] *Id.* at Ex. 3.

[10] *Id.* at 23.

In Dr. Davison's letter to respondent of June 20, 2002, claimant was given restrictions not to use that hand. Due to the amount of complaints about discomfort in the hand Dr. Davis chose to send claimant to physical therapy with a followup visit in a week. Otherwise, claimant could go to work and perform duties that respondent deemed suitable. Claimant was then placed in an accommodated job watering the plants, trees and bushes respondent received. However, claimant testified he had a hard time dragging the hoses around. Claimant tried performing this job for approximately two-and-one-half days before he told respondent he could no longer perform the job as the hoses were too heavy.

Claimant last saw Dr. Davison on July 11, 2002. This was for the final check of his injury. Dr. Davison's chart notes reflect that claimant had finished his occupational therapy and at that point claimant showed excellent range of motion of the finger tip, with not much swelling. Dr. Davison noted there was a little evidence of trauma to the nail matrix but no other swelling or discoloration. Claimant did mention a numbness or a tingling sensation of the finger if he taps it and described it as going down to his palm. Dr. Davison assessed claimant as post finger fracture which had healed very well. Dr. Davison did not believe that occupational therapy would benefit claimant any further and told claimant the neuropathy would eventually resolve over time.

On July 18, 2002, claimant called Dr. Davison's office after receiving a copy of his medical records. Claimant disagreed with Dr. Davison on several statements contained in those records. Dr. Davison told claimant he could disagree and to correct the records and his attachments could be placed in the medical file. Claimant reported feeling 65 percent better but that he had a great deal of swelling and pain with the use of the hand. However, Dr. Davison explained to claimant he was not in a position to continue with his care and informed claimant that he was willing to care for him until he could obtain another physician.[11] Claimant at that point requested to see a specialist.

Claimant requested a referral to a neurologist or hand specialist but Dr. Davison did not refer him. Claimant testified his relationship with Dr. Davison at this point "wasn't like it should have been"[12] and on September 25, 2002, Dr. Davison sent a letter to claimant informing him that he was withdrawing from further professional attendance of claimant except for emergencies for a period of 14 days from the date of the letter.[13] Claimant testified that he then started working with respondent's insurance carrier to obtain referrals.

In a August 14, 2002 letter to respondent's insurance carrier Dr. Davison noted claimant "had a great deal of pain throughout the convalescent stage, which was somewhat perplexing given the lack of physical findings. In addition, Mr. Sutton was

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[11] *Id.*

[12] *Id.* at 17.

[13] Davison Depo. at Ex. 3.

evaluated by occupational therapy who concurred with the diagnosis and the fact that he was improving."[14] Dr. Davison did not think claimant would have any long term disabilities.

Claimant, on his own, sought a consultation with his family doctor Xavier F. Ng, M.D., in August 2002. Thereafter, respondent authorized claimant to see Dr. Ng. Claimant testified Dr. Ng thought that since claimant smashed his hand this could have caused nerve damage and believed further testing needed to be done. He recommended claimant see a hand specialist.

Claimant testified that from the period of time between the last time he saw Dr. Davison and the time he saw Dr. Ng he had restrictions of "[n]o use of the right hand."[15]

Claimant next received treatment on October 31, 2002, from Timothy S. Wolff, D.O. On that date claimant had complaints of pain in the right hand with most of the discomfort being between the knuckles. Claimant stated this makes him irritated which causes his blood pressure to rise and tension in the right shoulder that radiates up into his neck and causes him headaches. Claimant described the pain as worse in the night time. Dr. Wolff noted claimant was animated in his discussion regarding his injury. Dr. Wolff also noted during his explanation he was able to move the hand and right upper extremity without any difficulty nor did he have any difficulty with the range of motion, stability, strength or tone. Dr. Wolff noted the range of motion of the fingers was full, stability was intact, strength appeared to be normal and tone was normal. Dr. Wolff did examine the right shoulder and found mild tone increase in the trapezius with a mild first rib superior subluxation noted on the right. He noted range of motion was full in the shoulder and elbow and the stability was intact in the shoulder and elbow. Neurologically, he did not see any abnormalities. Dr. Wolff's assessment was right hand pain, history of previous right index finger tuft fracture, right shoulder pain, and right trapezius spasm mild. After reviewing the x-rays, he noted he had difficulty seeing the tuft fracture. And noted he was concerned with other ulterior motives. Dr. Wolff recommended followup with Dr. Gluck, a hand specialist, to conduct nerve conduction tests and an EMG. He prescribed claimant medications and imposed restrictions to not use his right hand until claimant was seen by Dr. Gluck or a hand specialist.

On November 13, 2002, claimant was seen by Sam Heck, D.O. Apparently, claimant sought medical treatment through Dr. Heck after claimant consulted with his counsel and was told to again seek treatment with Dr. Wolff, and Dr. Heck is in practice in the same group. Claimant was requesting a refill of his prescription. Dr. Heck performed an examination and noted claimant had good range of motion in the right wrist but noted tenderness over the carpal bones and the proximal portion of the hand, hypothenar and

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[14] P.H. Trans at 17 (Dec. 17, 2002).

[15] *Id.* at 27.

thenar eminence area. He noted claimant had some weakness with the right grip being worse than the left grip. Dr. Heck treated claimant with a refill of medications and ordered an MRI of the right forearm and hand. But it is not clear whether an MRI was ever performed. Dr. Heck also imposed restrictions of no work with the right hand until claimant was seen again by Dr. Wolff or Dr. Heck on November 20, 2002.

Claimant testified that he was not able to work during the summer between June 16th and the time he saw Dr. Stein.[16] Claimant explained he could not work as he had a lot of pain in his hand. When he would grab things, he felt tightness and pain that caused it to swell. Claimant described the pain as a tightening in his neck on the right side with severe headaches. Claimant testified there were no jobs with respondent that he could do.

At the request of respondent's insurance carrier claimant was evaluated on November 18, 2002, by Paul Stein, M.D., for an independent medical examination. Dr. Stein is a board certified neurosurgeon. He obtained a history from claimant, reviewed x-rays and performed an examination. Upon examination claimant was complaining of tenderness and pain in his right hand, particularly involving the third and fourth carpal-metacarpal joints along with swelling. Claimant described his fingers as getting ice cold. Claimant also reported his hand is clumsy with poor coordination and he has difficulty holding onto things because of the pain. He also stated that when the hand is very cold, the tips of the third and fourth fingers feel numb and frozen. Dr. Stein noted that Phalen test was negative bilaterally. He also noted that the Tinel signs were not present over the median nerves at the wrists or the ulnar nerves at the elbows. Dr. Stein did not believe claimant's primary pathology was related to the fracture itself and did not believe it to be of any concern. However, Dr. Stein did report a very substantial difference in the temperature of claimant's hands and some difference in coloration. Dr. Stein stated that they may be dealing with a form of complex regional pain disorder (reflex sympathetic dystrophy) or vascular injury or vasospasm like Raynaud's syndrome. Dr. Stein recommended further evaluation for possible diagnoses such as a triple phase bone scan of the right hand or a vascular evaluation together with possible thermography should be considered. Dr. Stein also believed a stellate ganglion block on the right might be helpful for therapeutic and/or diagnostic purposes. Dr. Stein noted that claimant is capable of working with this left upper extremity but should not be required to do any work activity with the right.

At some point claimant was given a choice of physicians and he selected George L. Lucas, M.D., a hand specialist. Claimant saw Dr. Lucas on two occasions. The first visit was on January 24, 2003, and a followup on March 21, 2003. In the interim claimant was examined by Ron Manasco, M.D., for two stellate ganglion blocks. Apparently claimant was scheduled for a third stellate ganglion block but that appointment was cancelled as Dr. Manasco had an emergency.

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[16] P.H. Trans. at 27 and 28.

Claimant's first visit with George L. Lucas, M.D., was January 24, 2003 for an examination. Claimant had complaints of getting spasms, with the hand being cold. Dr. Lucas diagnosed claimant with mild reflex sympathetic dystrophy.[17] Dr. Lucas requested Dr. Manasco to see claimant for stellate ganglion blocks. Dr. Manasco also treated claimant with steroid injections in the neck through his throat.[18] Claimant testified the shots caused additional problems with tightness in his right shoulder.[19] In his January 27, 2003 letter to respondent, Dr. Lucas did note that claimant had a slight coolness on the right side as compared to the left . . . there is a difference right to left."[20] Upon examination Dr. Lucas noted claimant had no gross sensory deficit, that claimant did have full range of motion, and had a fair grip strength. Claimant did not have a specific Tinel's sign along the course of the median or the ulnar nerve in the forearm. The x-ray revealed a healed tuft fracture on the edge of the right ring finger. No other abnormalities were noted and no osteopenia was noted. Dr. Lucas diagnosed mild reflex sympathetic dystrophy. Dr. Lucas referred claimant to Dr. Manasco for purposes of a stellate ganglion block. Claimant was given restrictions to avoid lifting of more than 20 pounds but that he could do light work. Claimant was to return to Dr. Lucas after the stellate ganglion blocks were completed.

Claimant presented again on his own to Dr. Lucas' office on March 22, 2003 for an evaluation of neck pain after receiving a ganglion block on March 14, 2003. Claimant reported the ganglion blocks made him nauseated and he had difficulty swallowing. After mentioning to Dr. Lucas something about flickering lights and wiring in the walls, Dr. Lucas suggested that maybe his problem was more in the brain than in his hand. It was at this point claimant accused Dr. Lucas of coughing in his face and Dr. Lucas invited claimant to leave his office and apparently security was called and claimant was escorted out of his office. Therefore, Dr. Lucas did not have a chance to examine claimant's hand on this visit nor to make a judgment regarding his impairment. Claimant testified that Dr. Lucas released him after his second appointment. It is worth noting that Dr. Lucas' chart note on this day reflects claimant had previously been restricted from service in the clinic due to past problems.[21]

Since claimant did not receive any treatment from Dr. Lucas he went to the emergency room March 26, 2003, and was treated for muscle spasms with muscle relaxers and medications. Apparently, the emergency room doctor told claimant to followup with Dr. Heck, a hand specialist.

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[17] Lucas Depo. at Ex. 1.

[18] P.H. Trans. at 9 (May 13, 2003).

[19] R.H. Trans. at 19 (Feb. 4, 2004).

[20] Lucas Depo. at Ex. 1.

[21] *Id.*

Claimant saw Sam Heck, D.O., again on his own, on March 26, 2003, for a followup visit. Dr. Heck requested an MRI and prescribed medications and referred claimant to Dr. Mark Melhorn.

At the May 13, 2003 preliminary hearing claimant testified he was continuing to have swelling and throbbing pain in the right hand along with fluctuation in temperature of the hand. Claimant testified as of that date he had not received any of the recommended testing that Dr. Stein had initially discussed in his report. Claimant also testified that Dr. Stein's report is not entirely accurate. Dr. Stein reported that claimant did not have any prior injuries to the right upper extremities when in fact he did have injuries in the past.[22]

Claimant was examined by J. Mark Melhorn, M.D., on May 23, 2003 for a court-ordered independent medical examination. Dr. Melhorn is a board certified orthopaedic surgeon. Dr. Melhorn testified that based on claimant's history, the examination, a review of the x-rays and claimant's response to questions, it was Dr. Melhorn's feeling that claimant had:

> [A] reasonably good grasp of how the workers compensation system worked, that his subjective complaints appeared to be somewhat inconsistent and perhaps disproportional to the clinical examination and the reported mechanism of injury, and that based on my experience, training, and background that that combination oftentimes suggests that the outcome to treatment will be less than optimal, and in this case I used the term 'prognosis is probably poor.'[23]

In his May 23, 2003 report, Dr. Melhorn diagnosed claimant with painful right upper extremity, dysfunctional painful right upper extremity and by history reflex sympathetic disorder (RSD), possible chronic regional pain syndrome (CRPS). Dr. Melhorn suggested treatment options including an EMG and nerve conduction studies of the right and left upper extremities. He also felt it would be reasonable to consider a 3-phase bone scan with regard to the right upper extremity, although he wanted to proceed with the EMG/NCT test first.

Claimant's EMG/NCT studies of May 27, 2003 were interpreted as normal with regard to both the right and left upper extremities.[24] As claimant's nerve conduction studies fell within a normal pattern Dr. Mehorn wanted to test claimant with a 3-phase bone scan for additional insight.

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[22] P.H. Trans. at 18 (May 13, 2003).

[23] Melhorn Depo. at 7.

[24] *Id.* at Ex. 2.

Dr. Melhorn believed claimant to be at maximum medical improvement on January 22, 2004, as there was no additional treatment that would change or improve claimant's subjective complaints. Dr. Melhorn and claimant discussed guidelines for what he could do with regard to physical activities at home and at work and then released him to followup on an "as needed basis." Dr. Melhorn outlined in the last paragraph of his report how claimant became assertive, demanding, and disruptive both to the patient/physician relationship and to the other patients in the office and to staff. Claimant elected to leave the office without seeking further medical advice and therefore, terminated the patient/physician relationship.

Dr. Melhorn opined that based on claimant's evaluation, review of the medical records and claimant's history, that claimant had 9.45 percent permanent partial impairment to the right upper extremity. This rating was based on a 7.15 percent of impairment due to pain and discomfort and loss of sensation, a 2.3 percent for impairment due to loss of strength and a zero percent impairment to the level of the skin. Dr. Melhorn testified his rating was limited to the right upper extremity.

Dr. Melhorn imposed permanent work guides of medium worked as outlined by the Occupational Safety and Health Administration (OSHA), with a maximum 50 pounds or less lift/carry; and frequent 25 pounds. In claimant's June 3, 2003 chart note Dr. Melhorn noted that for the unchanged part with regard to work guides, he was referring to eight (8) hours per day, 40 hours per week as the guide. With regard to the work characteristics, he was talking about an increase from light-medium to medium work, but was still recommending task rotation.

At claimant's attorney's request, claimant was examined by Pedro A. Murati, M.D., on July 16, 2003, for an independent medical examination. Dr. Murati is board-certified in rehabilitation and physical examination. He obtained a history from claimant, reviewed x-rays and performed a physical examination. Claimant complained of right hand and arm pain, numbness and neck pain on the right side with headaches. Dr. Murati opined that the work-related injury of May 10, 2002 resulted in claimant suffering from class one chronic regional pain disorder. Dr. Murati explained that the class one is now referred to as the reflex sympathetic dystrophy syndrome and the type two is referred to as nonsympathetically mediated pain. Dr. Murati rated claimant according to the *Guides*[25] at thirty-three (33) percent for loss of grip strength of the right hand, using table 34, on page 65, the claimant received a twenty (20) percent right upper extremity impairment which converts to a twelve (12) percent whole person impairment. For the neck strain, claimant falls into the DRE II for five (5) percent whole person impairment, using table the combined values chart, these whole person impairments combine to a sixteen (16) percent whole person impairment. Dr. Murati testified that claimant did have a sprain in the neck and that

[25] All references are to the American Medical Ass'n, *Guides to the Evaluation of Permanent Impairment* (4th ed.) unless otherwise specified.

the most effective way of treating it is to block the stellate ganglion which is in the neck,"[i]t usually extends to the brain, what a layman would understand as a chemical imbalance of the brain. . . ."[26] Dr. Murati imposed permanent restrictions based on an eight-hour workday These restrictions are occasional ladders and crawling, occasional above shoulder level work, no push, pull, lift, carry greater than 50 pounds and only occasionally at 50, frequently 35, and avoid awkward positions of the neck.[27] Using the task list prepared by Jerry Hardin, Dr. Murati believed claimant has a 19 percent task loss.

At the request of claimant's attorney claimant was interviewed on September 8, 2003, by Jerry Hardin a vocational expert for the purpose of developing a job task list based on a 15-year work history. At his April 6, 2004 deposition, Mr. Hardin said that as claimant was not working at the time of the interview claimant had a 100 percent wage loss. Mr. Hardin believed Dr. Murati was the only physician to impose restrictions on claimant. Mr. Hardin did not include an opinion in his September 26, 2003 report on what claimant's wage earning ability would be. However, he testified that claimant reported earning $600 a week in preinjury wages and believed claimant to still be able to earn that amount in an open labor market.

Linda C. Gerhardt is the director of human resources at Hall's Culligan Water. Ms. Gerhardt testified claimant began employment with Hall's Culligan Water on November 13, 2003, and was terminated on January 22, 2004. Apparently claimant had failed to return from an approved leave of absence. Claimant did not return or call in for one workday. They consider that to be a voluntary termination of employment. This policy is explained during the orientation process. Ms. Gerhardt testified claimant's termination was in no way linked to his physical complaints or his medical treatment. It was because he failed to report to work.

Blake Veenis, M.D., is a board certified independent medical examiner. At his April 13, 2004 deposition Dr. Veenis testified he treated claimant in 1996 and 1997 for prior work-related injuries. Claimant's last visit with Dr. Veenis was March 27, 1997. Dr. Veenis testified that claimant's primary complaint when he treated him in 1996 and 1997 was right shoulder pain, which spread into the right side of his neck, with symptoms radiating down into the right arm. At the time of claimant's last visit he was still having pain "in the shoulder and upper trapezius region extending into the neck."[28] Some of Dr. Veenis' reports reference both symptom magnification and somatization. Dr. Veenis explained that those terms are used with an individual has a problems and their response to the problem is more exaggerated, more heightened, that what one would expect, which leads to greater difficulties in treatment. Someone who is somaticizing takes emotional distress and re-

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[26] Murati Depo. at 13.

[27] *Id.* at 10.

[28] Veenis Depo. at 8.

channels it into physical problems. Dr. Vennis had not treated claimant for a crush injury to the hand or any limb.

Harry A. Morris, M.D., treated claimant for a prior 1995 work-related injury. Dr. Morris is board certified in orthopedic surgery with a speciality in limb surgery. He testified at his May 7, 2004 deposition that he treated claimant for pain in his right shoulder. The medical records reflect Dr. Morris treated claimant for pain radiating from the right shoulder into the neck and trapezius muscles and down and into the right arm. There were no complaints of problems in the hand or forearm.

Claimant was examined by Philip R. Mills, M.D., on December 3, 2003, for a court-ordered independent medical examination. Dr. Mills is board-certified in physical medicine. Dr. Mills took claimant's history, reviewed medical records, and performed a physical examination. Dr. Mills determined claimant was at maximum medical improvement. Dr. Mills diagnosed claimant with status post right finger tuft fracture with mild reflex sympathetic disorder (RSD) . Dr. Mills opined the tuft fracture was completely healed and the RSD had resolved and noted there was no causalgic type tenderness at that time. Dr. Mills noted myofascial component of discomfort with diffuse shoulder and arm pain. Dr. Mills encouraged claimant to stay active and did not restrict him for the tuft fracture. Dr. Mills opined that "to a reasonable degree of medical probability, there is a causal relationship between the examinee's tuft fracture and the reported injury with a subsequent RSD."[29] Based on the *Guides*, Dr. Mills opined that claimant suffered a one (1) percent permanent partial impairment to his right arm for the subjective complaints of discomfort.

Based upon the record as a whole, the Board finds and concludes that the greater weight of the credible evidence supports that ALJ's finding that claimant's injuries and resulting disability are limited to his right upper extremity. With the exception of the ALJ's award of temporary total disability compensation, the Board adopts the ALJ's findings of fact and conclusions of law as set forth in the Award.

WHEREFORE, the Appeals Board modifies the June 17, 2004 Award entered by Administrative Law Judge John D. Clark, to deny claimant temporary total disability compensation but otherwise affirms the Award.

As of March 31, 2005, claimant is entitled to 2.1 weeks of permanent partial disability compensation, at the rate of $266.68 per week, in the amount of $560.03 for a one (1) percent loss of the use of the right arm, making a total award of $560.03.

IT IS SO ORDERED.

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[29] Philip R. Mills, M.D., report to the Honorable John D. Clark dated Dec. 3, 2003 at 6 (filed Dec. 31, 2003).

Dated this ____ day of April 2005.

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BOARD MEMBER

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BOARD MEMBER

_____
BOARD MEMBER

c: Stephen J. Jones, Attorney for Claimant
Bradley J. LaForge, Attorney for Respondent & American Home Assurance Co.
John D. Clark, Administrative Law Judge
Paula S. Greathouse, Workers Compensation Director